Commonwealth of Virginia DMHMRSAS

The Partnership Press

Restructuring the Services System Through Regional Partnership Planning

Mark R. Warner
Governor of Virginia

A Monthly Publication

James S. Reinhard, M.D.
Commissioner

Department of Mental Health, Mental Retardation and Substance Abuse Services
Office of Legislation and Public Relations
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A Message From Commissioner Reinhard

As noted later in this issue, the Department is updating its vision. We believe it is important to clearly articulate what we would like the service system to look like as we continue to restructure the system. The Restructuring Policy Advisory Committee (RPAC) - which has broad representation from consumers, advocates, private providers, Community Service Boards, Facility and Department staff - provided helpful feedback regarding this vision. Hopefully you will notice that we have intentionally listed **Self-determination, Empowerment, and Recovery** as the first category in the proposed vision.

These important concepts have been articulated by consumers for approximately the past 20 years or more, but are just now starting to receive the attention they deserve. For example, the President's New Freedom Commission Final Report has espoused the idea most strongly in their vision statement by stating, "We envision a future when everyone with a mental illness will recover… " Likewise, CMHS director Kathryn Power is utilizing the concept of recovery and empowerment as the centerpiece for the federal government's role in transforming the mental health system. We continue to educate ourselves and the system on how these concepts pertain not only to mental health and substance abuse, but also for all illnesses and disabilities.

I am convinced that our system will not be restructured appropriately until we fully understand, fully embrace, and fully implement the concepts of self-determination, empowerment and recovery. Those concepts are just as important for providers, administrators, family members, and advocates as they are for the people who receive services. Administrators, staff members, providers, family members – in addition to consumers - need to feel that there is unquestionable hope for improvement and that they are empowered to make meaningful changes.

It appears that many in the general public and the General Assembly – those that vote for and supply resources – must be currently skeptical that we need all the funding that we annually request in the budget process. Otherwise, why would they let thousands wait on lists or not fund so many requests? We need to continue to convince the public and our legislators that our system fully embraces self-determination, empowerment and recovery and that every single need and every single request for service is based on clear evidence that we truly need every single dollar that we are requesting. Not a penny less and not a penny more.

Our system has received, in the most recently approved budget, a down-payment of investing in our work. With significant numbers of waiver slots and money for "Olmstead initiatives" such as private bed purchase money, Discharge Assistance Plans (DAP), and Assertive Community Treatment teams (PACT) we have the opportunity to demonstrate that this investment was very wise, that we are using every penny wisely, and that community integration, self-determination, empowerment and focus on recovery is real wisdom!

Proposed Vision & Values Statements

WE WOULD LIKE TO HEAR FROM YOU…

A vision for the mental health, mental retardation, and substance abuse services system is being developed over the next three months to guide future actions for restructuring Virginia's services system. The Restructuring Policy Advisory Committee (RPAC) discussed a proposed vision statement on April 2, 2004. The proposed statement below incorporates RPAC's suggestions.

This vision will be an essential component of an Integrated Strategic Plan, which will be developed this fall and will incorporate recommendations of the Regional Partnerships and the Special Populations Work Groups. We invite your participation in developing this vision for our services system. Commissioner Reinhard and Department's senior management will be meeting with interested groups to share the Department's directions, seek feedback on the proposed vision statement, and discuss actions that should be taken to make this vision a reality in the Commonwealth.

If your group is interested in meeting with Commissioner Reinhard or Senior Staff of the Department, please contact Martha Mead (804-786-9048) or Stacey Atwell (804-786-1332) for more information.

Proposed Vision Statement for the Mental Health, Mental Retardation and Substance Abuse Services System
April 28, 2004

Our vision is of a community-based system of services that promotes self-determination, empowerment, recovery, and the highest possible level of consumer participation in work, relationships, and all aspects of community life. The foundation of this vision includes the following.

Self-determination, Empowerment, and Recovery

- Consumers express pride in their accomplishments and hope for their futures.
- Consumers are empowered and supported in defining and reaching their own goals and making decisions about their lives and the services they receive.
- Providers work to expand community service options that emphasize community integration and independent living.

Quality of Services

- System improvement is ongoing, with stakeholder involvement and feedback mechanisms about consumer and other outcomes built into the system of care.
- Services and supports are highly individualized to each consumer.
- Evidence-based and best practices are expected and required, with incentives and support for providers to learn and use these practices.
- Personal privacy and consumer information is respected.
- Effective services and management, innovation, and efficient use of resources are rewarded.

Access

- Services are consumer and family centered --
    1. Ability to pay is not an obstacle;
    2. Services are easy to navigate;
    3. Consumers and families receive clear information about service options;
    4. Consumers receive services and supports quickly and easily when needed;
    5. Language and cultural differences are respected and appropriately addressed;
    6. Services are provided in consumers' home communities as close to family and friends as possible; and
    7. Services are designed to be flexible.

- A full range of services and supports is available, with choices for consumers and families.
- Providers and policy-makers overcome fragmentation and barriers that limit access to health, education, employment, housing, and other community services and supports.

Accountability

- Policy-makers and providers at the state and local levels meet the highest standards of accountability, with performance monitored with stakeholders through an open process.
- Consumer outcomes are measured and monitored to assure that services are effective.
- Systems of accountability will encourage and not discourage organizational learning and systems improvement.

Partnerships

- Consumers, families, and providers are partners in treatment.
- Leadership at all levels works collaboratively with stakeholders through a partnership process where operations, policy, and funding matters and issues are addressed.
- State and local governments work with public and private providers to make services available in settings that are the most appropriate to the needs of individual consumers.
- The academic community partners with public and private providers to ensure clinicians and direct care staff are skilled in evidence-based and best practices.
- Stakeholders have a variety of opportunities for involvement, input, and consensus building.

Coordination

- CSBs are the local points of accountability for the coordination of publicly funded mental health, mental retardation, and substance abuse services.
- Regional structures collaboratively manage service utilization across the region and provide services that are beyond the capacity of a single CSB.
- Providers, consumers, and family members communicate to coordinate care at both the individual and system levels.

Funding

- The services system will be appropriately funded to ensure sufficient capacity to address consumer needs.
- As services are developed in the community, the state share of services funding is maintained and increased to meet growing consumer needs and provide evidence-based and best practices.
- The state takes full advantage of federal sources of funding.
- Consumer needs drive policies that govern eligibility for and use of state and federal funds.

Efficient Use of Resources

- Consumers receive the level of service they need, when they need it, in the appropriate amount, and for the appropriate duration.
- Policies and practices at all levels support the most efficient use of resources.
- Preventive and early interventions are encouraged and supported.

Over the next few months, the Department hopes to receive additional feedback from a wide variety of services system partners.

Regional Updates

Central Region (Richmond–Metro Area)

Regional Activities: The Crisis Stabilization Unit (CSU) that became operational in October, 2003, continues to offer excellent clinical services to consumers who are at risk of more restrictive levels of care. As of March 31, 2004, the CSU has served 81 individuals with an average length of stay of 5.41 days. The program has been particularly useful to consumers who are involved with the long-term support programs of the participating agencies. Of note is the high incidence of individuals with co-occurring mental health and substance abuse issues. At least 52 of those served have current substance use or a history of drug/alcohol problems. To date, 25 consumers have required stays longer than 5 days and 6 of those have extended stays between 10 and 15 days. Rubicon (the contractor for this program) and RBHA (Reinvestment Fiscal Agent) are working together to improve Medicaid reimbursement capability for the crisis service.

The region hired two consultants (Bert Pepper and Ed Hendrickson) to review the current circumstances in the three jails (Richmond City, Riverside & Dinwiddie County) selected by the region for programming. The consultants also provided a menu of choices for the region to use as a guide to implementation of the jail-based program. The final report of the consultants has been received and recommendations are being reviewed and implemented as needed. Interviews are scheduled for the jail team psychologist. The therapist/case manager position has been advertised. The RN job requirements have also been finalized and a position vacancy will be posted. Central State Hospital is recruiting for the psychiatrist for this program.

The Consortium has decided to contract for the Regional Behavior Team. A Memorandum of Agreement has been finalized with Virginia Commonwealth University to operate this program. Recruitment has begun for completing the staffing for this component of the program.

Discharge plans have been completed for three individual consumers to utilize the intensive one-to-one supervision pool of funds to support their discharge from Central State Hospital. One consumer with both mental health and mental retardation disorders has been successfully placed with the additional funds from this pool. Two other current residents of Central State are participating in trial visits preparing for discharge to settings where special additional supports are needed to improve the opportunity for successful placement.

The Nursing Home component of the Reinvestment Initiative remains the most challenging of the planned services to implement. Due to lack of interested vendors, a Task Force has been appointed by the Consortium to move this implementation forward. Currently, the region is negotiating with a local nursing home that has indicated a willingness to consider providing an 8 bed unit dedicated to serving the needs of those with mental illness that also require intermediate level nursing care. In addition, the task force is reviewing proposals from several consultants who would provide a feasibility study as to what alternatives might be available to the region for serving this population. The Consortium believes that this population will, in the near future, represent a larger segment of the service population and that proactive efforts to prepare for this service need should be made. Under consideration, in addition to the continued efforts to find suitable placements on an individual consumer basis, is the possibility of developing a regional facility specializing in providing services to this population or finding a vendor who would be willing, with start-up support, to initiate this type of service program.

The Region IV Partnership Planning Committee held an all day Planning Retreat March 8th. The Retreat was facilitated by Joan Durman of Durman Associates. The Steering Committee considered all the input it had received throughout 2003-04 from regional Public Hearings, regional Focus Groups, a Priority Needs Regional Survey, and a Regional Demographics Analysis Report contracted

Regional Updates (continued)

through Central Virginia Health Planning Agency (CVHPA). A Retreat report resulted which focused on five priority regional initiatives for action. One was an ongoing initiative to establish mental retardation emergency beds and a CSB-professionally staffed "hotel" program at Southside Virginia Training Center. Second was a restructuring of Turning Point regional substance abuse residential services and referral process. Third was an in-jail Substance Abuse Social Recovery initiative that could be a supplemental component of the region's in-development reinvestment Jail Team Project. Fourth was to conduct further study and planning for alternatives to inpatient care for adults and/or children with focus on sub-acute crisis stabilization and supervised living. Fifth was to establish a regional structure/mechanism for enhanced private hospital and public sector collaboration for coordination of care and care management for adults with chronic, serious mental illness and dual diagnoses. The report also identified several associated systems issues/needs for priority attention: utilize population-based and pooled funding pilot program approaches; use recovery models; focus on need for more public resources coupled with needed Code/regulation changes; link core services with ancillary services (ex. vocational, transportation); provision of services for "aging-out" children, increase focus on substance abuse prevention, and prioritization of co-occurring disorder planning in all disability areas. The Steering Committee will be meeting over the next three months to conduct further planning sessions that will result in final recommendations to the DMHMRSAS Commissioner per published DMHMRSAS reporting expectations.

Southern Region (Southside Virginia)

Regional Activities: Discussions have been held between the local CSBs (Danville Pittsylvania Community Services, Piedmont Regional CSB, and Southside CSB) and SVHMI and the local hospitals for an inpatient services protocol. The three hospitals are located in Martinsville, Danville, and South Hill and these private hospitals are now handling emergency, psychiatric care cases. Danville-Pittsylvania Community Services has made arrangements to staff on a 24 hour basis the psychiatric unit at Danville Regional Hospital as a matching contribution and, with SVMHI participation, divert patients from SVMHI by the admissions to Danville Regional Hospital.

Southside CSB has an ongoing inpatient services arrangement with the Pavilion (free-standing unit at Community Memorial Hospital in South Hill) whereby Southside CSB pays for inpatient bed days at an agreed upon rate with funds paid from their regular budget. With these funds now exhausted, the Pavilion, SVMHI and Southside CSB have finalized an arrangement that will have SVMHI pay for bed days for the remainder of the fiscal year. As a practice, Southside CSB has a long-standing arrangement with the Pavilion that states the length of stay for any hospitalization must have the prior approval of the CSB beyond the commitment hearing at the facility.

Piedmont CSB has been holding discussions with the hospital in Martinsville concerning emergency cases and the issue of diverting admissions from SVHMI to the extent possible.

Southside Behavioral Health Consortium has invited representatives from the Department of Urban Affairs and Planning at Virginia Tech and the Institute for Innovative Governance through the School of Public and International Affairs (located in Danville) on how the academic resources from the university can be utilized in the organizational development of the Consortium and in the Consortium's planning efforts. Several meetings have already been held and a formal protocol is being considered at this time.

Issues concerning the development of services at a collective level are still being discussed, while preserving the integrity of meeting service needs through the local CSBs is maintained. The Consortium meets on a regular basis with the three member CSBs and SVMHI in attendance.

Regional Updates (continued)

Far Southwestern Region (Southwestern Virginia)

Reinvestment and Restructuring: A Pilot Proposal for Private Bed purchase in the western portion of our region has been endorsed by the SWVA Behavioral Health Board and is being formalized by the 4 CSBs that make up this portion of the region. With investment into the region, it is believed that the region can expand treatment options for consumers needing acute inpatient interventions by treating them closer to home and reducing their displacement to the state facility in the absence of a funded payor source. The Southwest Virginia Behavioral Health Board and the individual CSBs served in the region have explored regional and sub-regional proposals and agree that investment from the DMHMRSAS is necessary to realize any meaningful change in acute admissions at the state facilities. More than one third of the acute admissions to the SWVMHI have an identified payor source at the time of the prescreening. Identified barriers to admission to one of the four private psychiatric hospitals in our 17 counties are most often bed availability and complex rehabilitation needs. With a limited number of private facility acute admission beds, the beds are often filled quickly on a first come, first served basis with TDO admissions and subsequent referrals of TDO admissions (even with payor sources) must be admitted to the SWVMHI. A lack of inpatient treatment options for substance abuse disorders is also a factor in the lack of available beds and increased admissions to SWVMHI.

The MR/MI program, PATHWAYS, at the SWVTC continues its mission of short-term treatment for the dually diagnosed. Technical assistance consultation to requesting CSBs and service sites has been positively received. An educational project for the community and providers is underway with the goal of producing informational pamphlets for the public and increasing intervention skills of providers for the dually diagnosed.

Regional Partnership Planning: Workgroups of the Southwest Virginia Behavioral Health Board are meeting to resolve specific, assigned issues. The Transitions to Reinvestment Workgroup has begun its Utilization Review process and is identifying opportunities for resource development to decrease SWVMHI acute admissions. The Emergency Services Workgroup is assisting in the data collection of this utilization review process and meets regularly to discuss emergency services issues. Specific members of the SWVBHB are part of the state level process of reviewing the Discharge Protocols and Utilization Management.

The SWVBHB will be part of a pilot for the Virtual Private Network implemented by the Department to allow real time interactive process between SWVMHI, SWVTC and the 6 CSBs in order to cooperatively and simultaneously complete discharge plans and needs.

Northwestern Region (Valley and Northwestern Virginia)

Reinvestment activity is going well. The region discharged more than enough people (35) from Western State Hospital to close a unit. In addition, the region has maintained approximately $190,000 for bed purchase should Western State's census get to a point that someone on a TDO who otherwise would be appropriate for admission cannot be admitted. To date, these dollars have been used for one person.

The annualized cost of the 35 plans is approximately $80,000 more than the amount available from the closing of the unit for FY05. Therefore, the Utilization Management Team, made up of staff from the region's CSBs, Western State Hospital and the Department, will do an audit of the plans on May 13. New, updated plans are due to the committee May 3. It is believed that the actual cost of the discharges is less than estimated and that the needed dollars will be found through this process.

An outgrowth of the Restructuring process was the development of a committee made up of CSB, Western State and private acute care facility staff. This group worked on a plan for the use of private beds in the region. The result of their work was the formation of a spin-off committee to

Regional Updates (continued)

work with a part-time Utilization Management Coordinator to develop a protocol for hospitalization of the region's consumers should a bed be unavailable at Western State. This was accomplished. The second phase of this committee's work will be to develop a protocol for a mental health diversion project as well as develop plans for the utilization management of public beds. This work is just beginning.

Northern Region (Northern Virginia)

HPR II is actively working toward completion of the myriad of activities that have been undertaken during this second phase of the regional Partnership Planning Project. Under the leadership of a Steering Committee representing a broad stakeholder group, three major workgroups are in the process of finalizing recommendations.

The Mental Health Work Group has worked closely with the Office of Forensic Services in Central Office to develop a database that will assist in clarifying present as well as future service needs of people who are on NGRI and other Forensic statuses. In addition, an NVMHI consumer participant in the planning process has conducted focus groups within the Institute. Several important recommendations from these groups were forwarded to the Mental Health Work Group for review. One of the recommendations involves creating an NGRI handbook that could be useful for consumers, lawyers and family members. A Co-Occuring Disorders subgroup, comprised of Institute and CSB SA staff, have begun to work in partnership. They have developed mission and value statements and are working closely with the statewide special populations workgroup. The third subgroup of the Mental Health Work Group is planning a Regional Recovery Conference to be held in the Fall 2004.

The Private Psychiatric Hospitals workgroup continues to be concerned with closures and/or relocations of private psychiatric beds. Current proposals involve potential closure of 92 beds. Partnership Planning Co-chairs, along with service delivery staff, have met with some private providers to discuss specific regional needs, especially with regard to children and youth services. Data characterizing populations served at NVMHI and each of the private psychiatric hospitals will provide a foundation for discussions in May that may further clarify public and private sector service delivery roles.

The Structural Workgroup is actively working on structures to continue the collaborative work in the region. Final models are being considered and are designed to provide a mechanism for ongoing planning, fiscal management of regionally based funds and effective integration of various existing groups.

Because adult mental health services has been the primary focus of regional planning thus far, efforts have been made to reach out to providers serving other populations in order to afford them the opportunity to identify service needs. Meetings have been held with those serving children and youth, including CSA Coordinators, as well as those serving older adults. In addition, the ongoing Mental Retardation/Mental Illness workgroup has made several reports to the Steering Committee and is close to finalizing recommendations, a number of which will be integrated with the statewide special populations recommendations.

Consistent with the regional commitment to have the broadest possible input into planning efforts, plans are underway to conduct a regional public forum in June. During this forum, all stakeholders will have the opportunity to comment on key aspects of the report that the Regional Parntership Planning Project will be finalizing in July.

Additional information regarding the activities in Northern Virginia can be obtained by going to the Partnership website at http://www.fairfaxcounty.gov/service/csb/region/partnershipmain.htm.

Regional Updates (continued)

Catawba Region (Roanoke Area)

The Catawba Regional Partnership Restructuring plan is moving ahead. Discussions with the Commissioner and his staff have been helpful in further developing and refining the concepts of the original restructuring plan.

Plans are under development to create a Regional Partnership Director position to assist with development and management of the Partnership projects and to ultimately be involved with the utilization management activities in this region.

One of the project goals is to have community clients attend the Treatment Mall at Catawba Hospital. The Treatment Mall would provide initial psychosocial interactions and would allow people without entitlements an opportunity to benefit from this service. The last stages of planning are underway and the target date to begin is July 1, depending on the status of the Partnership Director position.

A "Roadmap" to client services and entitlements is being developed for families and clients to use. The purpose is to give concrete, written information and directions to community resources needed by the consumer. The current plan is for the Mountain House Clubhouse to be paid a fee to maintain and update the Roadmap.

A community-based pharmacy is under development. Discussions between the Partnership members and the Alleghany Health District pharmacy are underway and a plan has been created.

Helen Ardan, RN
Blue Ridge Behavioral Healthcare

Helen Ardan, RN, Director of Community Support Services at Blue Ridge Behavioral Healthcare and Walton Mitchell, MA, Vice President of Patient Services at Catawba Hospital, staff support to the Catawba Regional Partnership, were awarded the Public Policy Award by NAMI-RV at their annual meeting on April 12, 2004.

Walton Mitchell, MA
Catawba Hospital

Eastern Region (Tidewater Area)

Highlights from the Eastern Region:

- HPR V Reinvestment Project have finalized contracts with Virginia Beach Psychiatric Center in Virginia Beach, Riverside Behavioral Center in Hampton and Maryview Behavioral Health Center in Portsmouth.
- HPR V Reinvestment Project is negotiating a contract with Shore Memorial Hospital in Nassawadox.
- The following committees comprise the HPR V Project: HPR V Regional Planning Partnership, Systems Oversight and Project Design, Regional Authorization Committee (RAC), Regional Discharge Action Committee and the Information Technology Committee.
- Measures of successful transition of acute inpatient care from ESH to community include: appropriate and sufficient access to acute inpatient care, clinical responsiveness of acute inpatient care, effective coordination between CSBs and acute inpatient providers.
- The project is working on additional issues, including: management of trend data that drives decisions, optimal community and facility bed capacity, enhanced community capacity, management of ESH discharge ready patients, use of DAP funds for Regional Project patients and management of patients with co-occurring conditions.
- Additionally, the project is interested in both research and evaluation components to determine project success; criteria is being established against which to measure success.

Geriatric Special Population Workgroup Update

Geriatric Special Population Team on Restructuring

Six Key Issues

The team identified six key issues in improving the services system:

1) DATA – Existing databases are not adequate for documenting service needs, evaluating service delivery, or planning improvements in the system.
2) CONTINUUM OF SERVICES – The existing community based continuum of care is inadequate for all levels of need.
3) SHORTAGE OF SPECIALIZED PROVIDERS – There are inadequate numbers of sufficiently trained providers for older adults with MH/SA needs.
4) FUNDING – Current public and private funding is insufficient to create incentives for needed expansion of services.
5) CAREGIVER SUPPORT – Insufficient supports are available to both professional and significant other caregivers who serve as primary caregivers and providers of services, and who do not have the skills to deal with MH/SA issues
6) UNCOORDINATED SERVICES – There is insufficient coordination of the existing geriatric psychiatry care provision systems causing decreased continuity and wasting of limited resources

Draft Recommendations

Preliminary recommendations that would help improve the system, related to the six key issues, have been drafted as of April 15, 2004.
Some recommendations are short-term, for implementation during the upcoming calendar year. Others are long-term, for implementation within five years.
The recommendations were developed by six separate work groups (one work group for each key issue). The work groups had previously participated in a review of the Olmstead recommendations that pertain to geriatric services, and incorporated these recommendations into their thinking. Major themes in the recommendations include:

1) Inventorying current services, agencies, and resources.
2) Providing information and education to caregivers and providers.
3) Preparing information for clients and their caregivers about services available to them and eligibility. (This recommendation has also been made by some of the regional planning teams, and has sometimes been referred to as Service Mapping.)
4) Identifying gaps in the existing continuum of community-based services specific to geriatric clients.
5) Compiling current data, and developing needed databases for use in identifying needs, planning and evaluating services, and coordinating service delivery.
6) Conducting studies of the specialized community-based service needs of geriatric clients.
7) Involving key agencies in collaborative joint planning to allocate funds and resources to support needed services.

There is widespread recognition that the geriatric population has not been identified as a priority population and will need to be given much greater visibility in planning and service delivery.

Next Steps

The team will now:

1) Review the draft recommendations and combine items where feasible.
2) Select a manageable number of recommendations to be submitted, including both short and long range goals and initiatives.
3) Develop each recommendation into a standard format that can be submitted for implementation.
4) Present a set of recommendations, in order of priority, in a report to the commissioner which is due on August 2, 2004.

Geriatric Special Population Workgroup Update (Continued)

Communication to Regional Restructuring Teams

1) Recommendations from the Geriatric Special Population Team will be communicated to the Regional planning teams so they can be included in regional implementation plans.
2) Regional teams will be invited to submit issues and proposals they would like to see considered by the Geriatric Team.
3) Ongoing collaboration with the regional teams will be important so that they can have input to the Geriatric Team, and the Geriatric Team can help the regional teams incorporate specialized state-wide plans specific to geriatric clients.

Forensics Special Population Workgroup Update

The April meeting of the Forensic work group was convened at the Virginia Museum on April 2, 2004, immediately following the recent RPAC meeting. Several members from the forensic group, including representatives from jails, the courts, hospitals and CSBs participated in the RPAC meeting prior to the work group session.

During the work group meeting, Michael Shank, of the DMHMRSAS Office of Mental Health presented a comprehensive overview of the PACT approach to community support of high-risk consumers. Anthony Vadella, CEO of Poplar Springs Hospital, and representative to the group from the VHHA, described the recent renovations at Poplar Springs that are designed to enable that facility to admit and treat low-risk offenders referred by local jails and juvenile detention centers. Dr. Margaret Fahey and Mr. Daniel Herr discussed the programmatic changes at Eastern State Hospital (ESH) and Central State Hospital (CSH) that are working to reduce the wait times for admission of criminal offenders for treatment at each of these facilities. Both hospitals have recently reduced their admissions waiting times.

The work group also considered further the draft report, and discussed the addition to its agenda of issues related to provision of community-based services to mentally ill offenders who have been released from the Virginia Department of Corrections.

SWVMHI and Far Southwest Region Expand Partnerships

Barry R. Jones, Art Professor at Emory & Henry College, has recently joined the far Southwestern Region of the Commonwealth and he is already making connections with consumers and advocates in the region. Barry's brother is diagnosed with schizophrenia and Barry has found meaning in understanding and sharing his brother's experiences through poetry to inform and influence his art (with his brother's permission). Since Barry's arrival in the region last August, a group of Emory and Henry professors and staff, family & consumer advocates, and CSB & SWVMHI staff have formed the Mental Health Creative Ideas Committee.

In the summer, Barry and his students will provide art experiences for consumers as described on his website (http://www.barryrjones.net/handsthatfly/), with an exhibition planned in the fall for MH Awareness Week. His theme is "Hands That Fly." The Mental Health Creative Ideas Community is working to tie the art exhibit with a presentation of Julie Portmann's play "My Sister's Sister" at E&H, some classes for consumers in therapeutic storytelling by Julie, and SWVMHI's Family Day.

In addition, Barry is working with Cynthia McClure, Director of SWVMHI, on a Cemetery Project to recognize the 1210 persons buried in the cemetery on SWVMHI grounds. The graves in the cemetery are neatly tended, but lack individual markers. This project will help raise awareness of those who have died and may help in a search to find financial support to improve the cemetery. Barry also has some exciting ideas for an art project about the cemetery.

What a wonderful example of a Partnership!

Major Legislation Tracked by DMHMRSAS 2004

2004 Regular Session Legislative Update
The following outlines briefly the major legislation tracked by DMHMRSAS during the Regular Session of the General Assembly.

Mental Health Services

SB 44, introduced by Senator Martin, repeals the scheduled July 1, 2004 sunset clause for the mandated insurance coverage for biologically based mental illness. This continues the statutory mandate for parity between coverage for mental illness and coverage for other illnesses.

SJR 25, sponsored by Senator Marsh, directs the Joint Commission on Health Care to study the mental health needs and treatment of young minority adults. This is a 2-year study.

Involuntary Commitment Process

HB 589, sponsored by Delegate Janis, was the result of a great deal of work involving the Sheriff's Association, the VACSB, the Hospital and Health Care Association and the Department. It incorporates Delegate Janis's HB 588 and Delegate Hamilton's HB 579. The final bill provides guidelines for a magistrate to use in specifying which law enforcement agency is to provide transportation for persons who are the subject of an emergency commitment order or temporary detention order. The bills allows localities to develop interagency agreements that specify who will carry out these duties.

Senator Marsh introduced **SB 24,** requiring a judge or magistrate to appoint an interpreter for a non-English speaking person who is the subject of or a witness in an involuntary commitment hearing.

HB 580 was requested by the VACSB and sponsored by Delegate Hamilton to resolve problems that arose with commitment hearings for children at the Commonwealth Center. It provides that the juvenile and domestic relations district court serving the jurisdiction where a minor is located is responsible for scheduling the involuntary commitment hearing. For emergency admissions, the hearing shall be scheduled where the child is located or resides.

Jail Services

SJR 81 and SJR 88 were recommendations of the Joint Behavioral Health Care's Subcommittee on Services to Offenders, and introduced by Senator Mims and Senator Martin. **SJR 81** encourages DMHMRSAS to provide nonfinancial assistance to localities in developing demonstration projects designed to divert individuals with mental illness, substance use disorders and co-occurring disorders from jail or secure detention. **SJR 88** Encourages the Departments of Corrections and Juvenile Justice to include a reporting component in any new mental health or substance abuse initiative that is established for offenders in their custody.

Early Intervention

HB 15 and **HB 205** were recommendations of the Joint Subcommittee Studying agencies, Boards, Commissions, etc. It abolishes the Early Intervention Agencies Committee. The interagency management team has taken over much of the work of this committee.

Substance Abuse Services

HB 745, introduced by Delegate Ware, and **SB 607**, introduced by Senator Wampler, respond to community concerns in Roanoke and Southwest Virginia over the location of methadone clinics. The final bills, which are identical, prohibit the granting of an initial license for a methadone clinic that plans to locate within one-half mile of a licensed public or private day care center, or a public or private K-12 school. Exceptions include clinics to be located in a hospital or on the grounds of a state hospital. Existing clinics are exempted, and are permitted to relocate within their own jurisdictions.

SB 93, Senator Devolites's bill, was defeated. It permits the hiring of persons to work in adult substance abuse treatment programs, regardless of previous criminal convictions, if the hiring provider determines that the criminal behavior was substantially related to their substance use disorder, and that the person has been substantially rehabilitated, and is not a risk to consumers.

SB 304, Senator O'Brien, creates the position of Special Advisor to the Governor for Workforce Development, and sets forth the duties. In addition, it requires the Substance Abuse Services Council to provide the Comprehensive Interagency State Plan to the Governor and General Assembly, and specifies requirements of the plan that are to be phased in during the next three years.

HIPAA

The Virginia Bar Association requested a number of bills designed to bring Virginia statutes into compliance with the federal Health Insurance Portability and Accountability Act. These bills are: **HB 876, HB 877, HB 878, HB 879 and SB 337.**

State Facilities

SB 556 was introduced by Senator Marsh in response to the location of the program for sexually violent predators (SVP) in Dinwiddie County. It requires the Commissioner to notify state elected officials and the local governing body of any jurisdiction where an SVP program is to be located. The locality is authorized to notify the public. The Commissioner is also required to establish a local advisory committee, and to notify the committee, upon request, whenever the number of beds at the facility is increased.

SB 628, introduced by Senator Devolites, requires that new employees complete a six-month probationary period before being eligible for short-term disability benefits for elective medical procedures, unless the procedure is certified by the program administrator, and unless the leave of absence is coordinated between the employer and employee.

Community Facilities and Guardianship

The VACSB requested the introduction of 3 bills designed to expand opportunities for community programs, and encourage individuals to be designated as guardians. **SB 197**, sponsored by Senator Reynolds, exempts intermediate care facilities for persons with mental retardation with 12 or fewer beds from the Certificate of Need process.

HB 350, introduced by Delegate Albo, authorizes guardians for consumers in the state facility system or community services system to participate in the state's risk management plan if approved by the Commissioner or Executive Director of the CSB.

HB 984, sponsored by Delegate Reese, allows local or regional tax-exempt charitable organizations to provide conservatorial or guardianship services. Under current law, only local or regional programs designated by the Department for the Aging may establish such public guardianship programs.

Office of the Inspector General

SB 212 was a result of the Code Commission's work to revise Title 37.1 of the *Code of Virginia*. Senator Edwards sponsored the bill that consolidates the *Code* sections defining the powers and duties of the Office of the Inspector General and the powers and duties of the person in that position. It clarifies that the IG can access information related to the delivery of services to consumers, however, the IG is not given access to peer review materials of licensed providers, i.e., private providers and CSBs.

Regional Leadership

Central Region:

Arnold Woodruff, Project Manager
Region IV Reinvestment Initiative
woodruffa@rbha.org 804-819-4187

Charles Davis, M.D., Director
Central State Hospital
cdavis@csh.state.va.us 804-524-7373

Catawba Area:

S. James Sikkema, Executive Director
Blue Ridge Behavioral Healthcare
jsikkema@brbh.org 540-345-9841

Jack L. Wood, Director
Catawba Hospital
jwood@catawba.state.va.us 540-375-4201

Eastern Region:

John Favret, Director
Eastern State Hospital
jfavret@esh.state.va.us 757-253-5241

Demetrios Peratsakis, Executive Director
Western Tidewater CSB
dperatsakis@wtcsb.org 757-255-7126

Northern Region:

James A. Thur, Executive Director
Fairfax-Falls Church Community Services
jthur2@co.fairfax.va.us 703-324-7000

Lynn DeLacy, Director
Northern Virginia Mental Health Institute
ldelacy@nvmhi.state.va.us 703-207-7110

Northwestern Region:

Jack W. Barber, M.D., Director
Western State Hospital
jbarber@wsh.state.va.us 540-332-8200

Charlotte V. McNulty, Executive Director
Harrisonburg-Rockingham CSB
cmcnul@hrcsb.org 540-434-1941

Southern Region:

Jules Modlinski, Ph.D., Executive Director
Southside Community Services Board
jmodlinski@sscsb.org 434-572-6916

David Lyon, Director
Southern Virginia Mental Health Institute
dlyon@svmhi.state.va.us 434-773-4230

Far Southwestern Region:

Derek Burton, RN, Project Manager
SWVA Behavioral Health Board
derekb@mrcsb.state.va.us 276-223-3242

Cynthia McClure, Ph.D., Director
Southwestern Virginia Mental Health Institute
cmcclure@swvmhi.state.va.us 276-783-1201

Sam Dillon, Executive Director
Planning District 1 CSB
pd1csb@mounet.com 276-679-5751

Dale Woods, Ed.D., Director
Southwestern Virginia Training Center
dwoods@swvtc.state.va.us 276-728-3121